TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE SOUTH DALLAS

MFDR Tracking Number
M4-18-0330-01

MFDR Date Received
October 10, 2017

Respondent Name
POLY AMERICA LP

Carrier's Austin Representative
Box Number 11

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... Dr. Hwang requested 80 hours of chronic pain management program... which were approved by the insurance company..."

Amount in Dispute: $7,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The services was pre-authorized by a company not affiliated with this account."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
July 24, 2017 through August 7, 2017	Non-CARF Chronic Pain Management (97799-CP)	$7,200.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Preauthorization/authorization/notification/absent

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for chronic pain management services rendered on July 24, 2017 through August 7, 2017. The insurance carrier in their position summary states in pertinent part, "The services was pre-authorized by a company not affiliated with this account."

   The requestor states in pertinent part, "... Dr. Hwang requested 80 hours of chronic pain management program... which were approved by the insurance company..."

   28 Texas Administrative Code §134.600(p) (12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes... (10) chronic pain management/interdisciplinary pain rehabilitation."

   The requestor submitted a copy of a preauthorization letter issued by Travelers, dated July 19, 2017 to support that preauthorization was obtained for the chronic pain management services in dispute. Review of the preauthorization letter presented by the requestor supports that preauthorization was obtained for a chronic pain management program, however the preauthorization letter is for another claimant with the same name, different date of injury, different carrier claim number and different employer.

   28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The Division finds that the requestor did not submit sufficient documentation to support that preauthorization was obtained for the chronic pain management services rendered to the injured employee identified on the DWC060 request. The Division finds that preauthorization was required and not obtained for the disputed services. As a result, the requestor is not entitled to reimbursement for the disputed chronic pain management services rendered on July 24, 2017 through August 7, 2017.
2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 27, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.